STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019471	A. BUILDING: _____ B. WING _____	R-C 10/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, WI 53711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments From 10/27/2025 to 10/30/2025, Surveyors conducted 3 complaint investigations, 2 verification visits and a standard survey at Courtyard at Fitchburg - Memory Care, a CBRF in Fitchburg. Twelve deficiencies were identified. Eight deficiencies were repeat deficiencies - See Statement of Deficiency (SOD) 5LT211, dated 05/07/2025 and SOD HT4311, dated 06/26/2025. Three of 3 complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed. Census: 22	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on observation, interview and record review, the provider did not ensure compliance was maintained with all laws governing the facility. This is a repeat deficiency. See Statement of Deficiency (SOD) 5LT211, dated 05/07/2025. Findings include: From 10/27/2025 to 10/30/2025, Surveyors conducted 3 complaint investigations, 2	N 196		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 196	Continued From page 1 verification visits and a standard survey. As a result of the survey, 3 of 3 complaints were substantiated and 12 deficiencies identified, 8 of which were repeat deficiencies. Through observation, interview and record review, the following concerns were identified: - Four of 6 residents reviewed did not receive their medications as prescribed. - One of 6 residents reviewed did not receive prompt and adequate treatment to a sore on his/her bottom. - Four of 6 residents reviewed did not have updated assessments related to behaviors, elopement and/or falls. - Two of 6 residents reviewed did not have their individual service plan (ISP) followed. - One of 6 residents reviewed did not have an updated ISP when his/her needs changed. - Three of 6 residents reviewed did not have their personal care needs met. - One of 6 residents reviewed did not have their health monitored as ordered. - One of 7 residents reviewed did not receive medication administration services to meet his/her needs. - A caregiver was observed assisting residents with eating without following hand washing procedures according to Centers for Disease Control and Prevention. - Bathrooms were observed in need of housekeeping and/or maintenance and soiled laundry was observed overflowing in baskets in resident rooms and/or leaving a urine odor in the room. - Residents who chose to eat in their rooms were served greater than 1 hour after mealtime and 1 resident who required assistance with eating was served by a caregiver standing over him/her.	N 196		

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N 196	Continued From page 2 On 10/27/2025 at 3:00 p.m., Surveyors reviewed concerns identified with Regional VP of Operations B, Regional Wellness Director C, Executive Director J, VP of Clinical Operations K and Associate Administrator L. Regional VP of Operations B stated many of the concerns revealed from alleged complaints were new concerns to him/her and several of the individuals participating in the exit had been at the facility until 8:00 or 9:00 p.m. at night most evenings. On 10/30/2025 at approximately 6:00 p.m., Surveyor reviewed the provider's compliance history. Records indicated that since issuing a probationary license to the provider on 09/20/2023 and regular license on 10/01/2024, the department has completed a probationary licensing, survey, 16 complaint investigations, 3 verification visits and a standard licensing survey. Department visits to the facility has resulted in 12 substantiated complaints and 36 deficiencies since 10/01/2024. Cross Reference: N0352 DHS 83.32(3)(h) Rights of Residents: Receive Medication N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment N0381 DHS 83.35(1)(a) Pre-Admission And Ongoing Assessments N0388 DHS 83.35(3)(c) Implement, Follow The Individual Service Plan N0389 DHS 83.35(3)(d) Service Plans Updated Annually And On Changes N0425 DHS 83.38(1)(a) Personal Cares N0431 DHS 83.38(1)(g) Health Monitoring N0432 DHS 83.38(1)(h) Medication Administration N0441 DHS 83.39(3) Hand Washing N0481 DHS 83.43(1) Environment Safe, Clean	N 196		

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COURTYARD AT FITCHBURG - MEMORY CARE (THE)	5683 WILSHIRE DRIVE FITCHBURG, WI 53711

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N 196	Continued From page 3 And Comfortable Y3234 DHS 50.09(1)(e) Treatment	N 196		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 6 residents reviewed received medications as prescribed. Resident 2 did not receive his/her Insulin Lispro units as prescribed. Resident 7 did not receive his/her Insulin Lispro Kwikpen units as prescribed. Resident 7 and Resident 3 did not receieve their insulin in the intervals as prescribed. Resident 8 did not receive his/her Metoprolol as prescribed. This is a repeat deficiency. See Statement of Deficiency (SOD) 5LT211, dated 05/07/2025. Findings include: From 10/27/2025 to 10/30/2025, Surveyors conducted 2 complaint investigations that alleged residents did not receive medications as	N 352		

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N 352	Continued From page 4 prescribed. RECORD REVIEW: On 10/27/2025 at approximately 10:00 a.m., Surveyors reviewed resident records and identified the following concerns: Example 1 - Resident 2's Insulin Units: Resident 2 was admitted to the provider's facility on 10/07/2024 with diagnosis of diabetes. Resident 2's physician orders included Insulin Lispro 100 unit/ml (Start Date: 09/15/2025) - 3 times daily at morning, noon and evening after meals per sliding scale of 0-139=0 units, 140-164=1 unit, 165-189=2 units, 190-214=3 units, 215-239=4 units, 240-264=5 units, 265-289=6 units, 290-314=7 units, 315-339=8 units, >339=Notify MD. Resident 2's medication administration record (MAR), dated 10/01/2025 to 10/27/2025, documented the following occurrences of Resident 2 not receiving his/her Insulin Lispro 100 unit/ml as prescribed: - 10/06/2025 at 8:02 a.m. Blood Sugar (BS)=300 - 8 units administered. *Per order, 7 units should have been administered. - 10/07/2025 at 8:19 a.m. BS=300 - 8 units administered. *Per order, 7 units should have been administered. - 10/17/2025 at 9:57 a.m. BS=279 - 9 units administered. *Per order, 6 units should have been administered. -10/18/2025 at 4:23 p.m. BS=148 - 4 units administered. *Per order, 1 unit should have been administered.	N 352		

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N 352	Continued From page 5 - 10/19/2025 at 4:39 p.m. BS=268 - 9 units administered. *Per order, 6 units should have been administered. - 10/20/2025 at 8:45 a.m. BS=196, 6 units administered. *Per order, 3 units should have been administered. Example 2 - Resident 7's Insulin Units: Resident 7 was admitted to the provider's facility on 10/09/2024 with a diagnosis of Type 1 diabetes mellitus. Resident 7's physician orders included the following: -8:00 a.m. - Insulin Lispro Kwikpen (Start Date: 08/21/2025) - Inject subcutaneously 4 units in the morning with breakfast, plus correction scale: BG (blood glucose) less than 150 = 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, Greater than 400 = 6 units. -12:00 p.m. - Insulin Lispro Kwikpen (Start Date: 08/21/2025) - Inject subcutaneously 6 units at noon with lunch, plus correction scale: BG less than 150 = 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, Greater than 400 = 6 units. -4:00 p.m. - Insulin Lispro Kwikpen (Start Date: 08/21/2025) - Inject subcutaneously 8 units in the evening with dinner, plus correction scale: BG less than 150 = 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, Greater than 400 = 6 units. -8:00 p.m. - Insulin Lispro Kwikpen (Start Date: 09/14/2025) - Bedtime correction scale: Less than 200 = 0, 201-250 = 1 unit, 251-300 = 2 units, 301-350 = 3 units, 351-400 = 4 units, greater than 400 = 5 units	N 352		

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N 352	Continued From page 6 Resident 7's MAR, dated 10/01/2025 to 10/27/2025, documented the following occurrences of Resident 7 not receiving his/her Insulin Lispro Kwikpen as prescribed: -10/01/2025 at 3:32 p.m. Blood Sugar (BS)=274 - 3 units administered. *Per order, 11 units should have been administered. -10/02/2025 at 8:01 a.m. BS=220 - 2 units administered. *Per order, 6 units should have been administered. -10/02/2025 at 11:57 a.m. BS=281 - 3 units administered. *Per order, 9 units should have been administered. -10/02/2025 at 7:27 p.m. BS=400 - 5 units administered. *Per order, 4 units should have been administered. -10/04/2025 at 4:19 p.m. BS=350 - 4 units administered. *Per order, 12 units should have been administered. -10/05/2025 at 7:59 a.m. BS=169 - 1 unit administered. *Per order, 5 units should have been administered. -10/05/2025 at 12:02 p.m. BS=200 - 1 unit administered. *Per order, 7 units should have been administered. -10/05/2025 at 3:38 p.m. BS=342 - 4 units administered. *Per order, 12 units should have been administered. -10/06/2025 at 7:50 a.m. BS=251 - 6 units administered. *Per order, 7 units should have been	N 352		

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administered.
-10/08/2025 at 4:25 p.m. BS=336 - 4 units administered.
*Per order, 12 units should have been administered.
-10/08/2025 at 8:08 p.m. BS=400 - 5 units administered.
*Per order, 4 units should have been administered.
-10/24/2025 at 4:39 p.m. BS=168 - 1 unit administered.
*Per order, 9 units should have been administered.
-10/26/2025 at 9:33 a.m. BS=236 - 2 units administered.
*Per order, 6 units should have been administered.

Example 3 - Resident 7's Time of Insulin Administration:

On 10/27/2025 at 8:10 a.m., Surveyor reviewed the facility's mealtimes: Breakfast: 8:00 a.m., Lunch: 12:00 p.m., Dinner: 4:30 p.m.

Resident 7 was admitted to the provider's facility on 10/09/2024 with a diagnosis of Type 1 diabetes mellitus. Resident 7's physician orders included the following:

-8:00 a.m. - Insulin Lispro Kwikpen (Start Date: 08/21/2025) - Inject subcutaneously 4 units in the morning with breakfast, plus correction scale: BG (blood glucose) less than 150 = 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, Greater than 400 = 6 units.
-12:00 p.m. - Insulin Lispro Kwikpen (Start Date: 08/21/2025) - Inject subcutaneously 6 units at noon with lunch, plus correction scale: BG less

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N 352	Continued From page 8 than 150 = 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, Greater than 400 = 6 units. -4:00 p.m. Insulin Lispro Kwikpen (Start Date: 08/21/2025) - Inject subcutaneously 8 units in the evening with dinner, plus correction scale: BG less than 150 = 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, Greater than 400 = 6 units. Each order included the following instructions: Do not administer insulin any greater than 15 minutes prior to mealtime. Resident 7's MAR, dated 10/01/2025 to 10/27/2025, documented the following occurrences of Resident 7 receiving his/her Insulin Lispro Kwikpen outside of the facility's mealtime hours: -10/01/2025 4:00 p.m. Insulin Lispro administered at 3:32 p.m. -10/05/2025 4:00 p.m. Insulin Lispro administered at 3:38 p.m. -10/06/2025 4:00 p.m. Insulin Lispro administered at 3:21 p.m. -10/09/2025 4:00 p.m. Insulin Lispro administered at 3:39 p.m. -10/12/2025 12:00 p.m. Insulin Lispro administered at 1:52 p.m. -10/13/2025 4:00 p.m. Insulin Lispro administered at 5:20 p.m. -10/17/2025 8:00 a.m. Insulin Lispro administered at 9:42 a.m. -10/20/2025 12:00 p.m. Insulin Lispro administered at 1:05 p.m. -10/20/2025 4:00 p.m. Insulin Lispro administered at 3:38 p.m. -10/22/2025 12:00 p.m. Insulin Lispro administered at 1:06 p.m.	N 352		

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N 352	Continued From page 9 -10/24/2025 8:00 a.m. Insulin Lispro administered at 9:39 a.m. -10/26/2025 8:00 a.m. Insulin Lispro administered at 9:33 a.m. -10/26/2025 12:00 p.m. Insulin Lispro administered at 1:30 p.m. -10/27/2025 8:00 a.m. Insulin Lispro administered at 10:19 a.m. Example 4 - Resident 3's Time of Insulin Administration: On 10/27/2025 at 8:10 a.m., Surveyor reviewed the facility's mealtimes: Breakfast: 8:00 a.m., Lunch: 12:00 p.m., Dinner: 4:30 p.m. Resident 3 was admitted to the provider's facility on 08/21/2025 with a diagnosis of Type 2 diabetes mellitus. Resident 3's physician orders included the following: Insulin Lispro Kwikpen U-100 100 Unit/mL (Start Date: 09/04/2025) - Inject 10 units subcutaneously 3 times a day in the morning, noon and evening with meals. Do not administer insulin any greater than 15 minutes prior to meal time. The Insulin Lispro was scheduled at 8:00 a.m., 12:00 p.m., and 4:00 p.m. Resident 3's MAR, dated 10/01/2025 to 10/27/2025, documented the following occurrences of Resident 3 receiving his/her Insulin Lispro Kwikpen outside of the facility's mealtime hours: -10/02/2025 12:00 p.m. Insulin Lispro administered at 1:42 p.m. -10/02/2025 4:00 p.m. Insulin Lispro administered at 3:52 p.m. -10/03/2025 4:00 p.m. Insulin Lispro administered at 3:48 p.m.	N 352		

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-10/04/2025 4:00 p.m. Insulin Lispro administered at 3:23 p.m.
-10/05/2025 4:00 p.m. Insulin Lispro administered at 3:26 p.m.
-10/07/2025 4:00 p.m. Insulin Lispro administered at 3:01 p.m.
-10/13/2025 8:00 a.m. Insulin Lispro administered at 9:02 a.m.
-10/16/2025 8:00 a.m. Insulin Lispro administered at 10:19 a.m.
-10/19/2025 4:00 p.m. Insulin Lispro administered at 3:55 p.m.
-10/20/2025 12:00 p.m. Insulin Lispro administered at 1:20 p.m.
-10/23/2025 8:00 a.m. Insulin Lispro administered at 9:56 a.m.
-10/24/2025 4:00 p.m. Insulin Lispro administered at 3:47 p.m.
-10/26/2025 8:00 a.m. Insulin Lispro administered at 10:17 a.m.

Example 5 - Resident 8's Metoprolol:

Resident 8 was admitted to the facility on 12/04/2024 and discharged on 09/25/2025.
Resident 8's physician orders included the following: Metoprolol Succinate 25 mg (Start Date: 08/26/2025) - Take 1 ½ tablets (37.5 mg) by mouth in the morning **hold if BP (blood pressure) less than 120/60 or HR (heart rate) less than 60**
Resident 8's MAR =, dated 09/01/2025 to 09/25/2025, documented the following blood pressure outside the specified parameter:

09/02/2025 8:36 a.m. - Metoprolol Succinate 25 mg administered / Blood pressure: 128/35 / Pulse: 66

According to WebMD, Metoprolol can lower blood

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N 352	Continued From page 11 pressure and should not be taken if blood pressure is too low (https://www.webmd.com/drugs/2/drug-8814-2372/metoprolol-succinate-oral/metoprolol-succinate-extended-release-capsule-oral/details#precautions). Mayo Clinic further explains a sudden blood pressure drop can be dangerous and can lead to dizziness, fainting, or shock (https://www.mayoclinic.org/diseases-conditions/low-blood-pressure/symptoms-causes/syc-20355465). Since Resident 8's diastolic blood pressure was 35 and the parameter for holding the Metoprolol was 60, the Metoprolol should have been held and not administered due to the risk of decreasing his/her blood pressure to a dangerous level. INTERVIEW On 10/27/2025 at 3:00 p.m., Surveyors reviewed medication administration concerns with Regional VP of Operations B, Regional Wellness Director C, Executive Director J, VP of Clinical Operations K and Associate Administrator L. Regional Wellness Director C acknowledged the provider had concerns with medication administration. Regional Wellness Director C stated a team of RNs were conducting audits, providing education to medication passers and removing medication passers from administration tasks as needed.	N 352		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt	N 353		

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N 353	Continued From page 12 and adequate treatment that is appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 6 residents reviewed received prompt and adequate treatment to meet his/her needs. The provider did not apply Resident 8's barrier cream as ordered on 09/10/2025, resulting in a stage 2 pressure injury to his/her coccyx. Findings include: On 10/27/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider's facility on 12/04/2024 with diagnoses including coronary artery disease, type 2 diabetes with diabetic chronic kidney disease, and deep vein thrombosis. Resident 8 discharged from the facility on 09/25/2025. Resident 8's Individual Service Plan (ISP), dated 05/23/2025, documented s/he was independent with ambulation and use of a walker, independent with toileting and continent of bowel and bladder and required standby assistance for bathing. Resident 8's ISP did not document his/her involvement with hospice. Resident 8's facility observation notes from 08/01/2025 to 10/01/2025 and medication administration record (MAR) for September 2025 documented the following: - Note on 09/11/2025 at 10:00 a.m.: Met with RN (registered nurse) from [hospice]. Request out to clarify O2 (oxygen) orders and to send parameters with order. Clarified shower schedule and care plan.	N 353		

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N 353	Continued From page 13 - Note on 09/11/2025 at 12:30 p.m.: ...Staff to provide peri care after each incontinence episode and reposition frequently. - MAR: Order - Toilet and reposition (Start Date: 09/16/2025) - Toilet and reposition (off load weight on buttocks) every 2-3 hours. On 10/27/2025 at 11:05 a.m., Surveyor interviewed Regional Wellness Director C about Resident 8's ISP. Regional Wellness Director C stated, "We use our own care plan and go through it with hospice." Regional Wellness Director C indicated s/he was unable to access the hospice care plan or notes for Resident 8 since s/he had discharged from the facility. On 10/29/2025 at 1:00 p.m., Surveyor reviewed hospice records, obtained by Surveyor. Hospice records indicated Resident 8 began hospice care on 08/07/2025. Hospice records, dated 09/01/2025 to 09/25/2025, documented the following: - 09/03/2025 - Hospice nurse noted episodes of urinary incontinence - Resident 8 was admitted to the hospital from 09/04/2025 to 09/08/2025 and discharged back to the facility. Hospice updated their care plan on 09/08/2025 to include the following changes: - Ambulation - Assist with ambulation with walker for short distances and assist with wheelchair for long distances - Toileting - Bedside commode added, requires supervision/assistance - Bathing - Shower / Supervision/assistance - Falls - discharged on 2 liters of oxygen via nasal cannula; added oxygen use and tubing to fall precautions - 09/09/2025 - Hospice nurse noted episodes of urinary and bowel incontinence	N 353		

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N 353	Continued From page 14 - 09/10/2025: Facility requested barrier cream for red spot on Resident 8's bottom. Hospice gave barrier cream to facility and put in an order to have it applied 3 times per day. - 09/16/20205: Noted stage 2 pressure injury on coccyx/buttocks area. Talked with facility. Order for barrier cream had been sitting in a queue and was not pushed through. Hospice indicated barrier cream would no longer be an appropriate treatment for the pressure injury. Talked with facility about incontinence care. Facility indicated a "change of status" order would be placed so staff would be required to perform cares. On 10/30/2025 at approximately 6:00 a.m., Surveyors' shared concern with Regional VP of Operations B that Resident 8 did not receive his/her barrier cream as ordered on 09/10/2025 and was found with a stage 2 pressure injury on his/her coccyx on 09/16/2025. On 10/30/2025 at approximately 5:00 p.m., Regional VP of Operations B replied that barrier cream was started on 09/18/2025 and discontinued on 09/26/2026. Regional VP of Operations B stated the barrier cream was administered as prescribed, in addition to wound care that began on 09/19/2025 and repositioning every 2-3 hours on 09/16/2025. Regional VP of Operations B did not comment on the delay of barrier cream administration or repositioning from 09/10/2025 to 09/16/2025.	N 353		
N 381	83.35(1)(a) Pre-admission and ongoing assessments. Scope. The CBRF shall assess each resident ' s needs, abilities, and physical and mental condition before admitting the person to the	N 381		

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N 381	Continued From page 15 CBRF, when there is a change in needs, abilities or condition, and at least annually. The assessment shall include all areas listed under par. (c). This requirement includes individuals receiving respite care in the CBRF. For emergency admissions the CBRF shall conduct the assessment within 5 days after admission. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 4 of 6 residents reviewed had an assessment completed when there was a change in needs. Resident 5 did not have an updated behavior, elopement or fall assessment. Resident 12 did not have an updated fall assessment. Resident 13 did not have an updated fall assessment. Resident 8 did not have an updated fall assessment. This is a repeat deficiency. See Statement of Deficiency (SOD) 5LT211, dated 05/07/2025. Findings include: From 10/27/2025 to 10/30/2025, Surveyors conducted a standard survey, 2 verification visits and 3 complaint investigations that identified the following assessment concerns:	N 381		

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N 381	Continued From page 16 RECORD REVIEW: Example 1 - Resident 5: On 10/27/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider's facility on 04/30/2024 with diagnosis of dementia. Resident 5's individual service plan (ISP), dated 05/29/2025, documented the following: - "[Resident 5] displays occasional agitation, anxiety, and can fluctuate emotionally daily depending on the situation. [Resident 5] experiences signs of sun-downing dementia mood swings that seem to worsen daily in the afternoon/evening. Care staff will provide services appropriate to [Resident 5]'s needs including helping to stabilize [his/her] emotional state with redirection and/or distraction techniques. Care Staff will take note of what agitates and emotionally upsets [Resident 5] and try to prevent these situations from happening by providing calm, polite redirection and/or distraction techniques as necessary ... [Resident 5] is occasionally non-compliant with/refuses cares. Care staff will provide assistance to [Resident 5] with managing [his/her] behavioral issues as necessary. Care staff will regularly encourage and remind [Resident 5] about the importance of cares and will attempt to get [him/her] to be compliant whenever possible by approaching [him/her] with a positive, kind, and calm attitude every time." - Resident 5's ISP was updated 09/22/2025, with an intervention of, "Toilet [Resident 5] before and after meals, upon rising and bedtime. Hope to decrease the incontinent episodes in public areas." *Surveyor noted this was a repeat intervention as the ISP already documented to	N 381		

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N 381	Continued From page 17 assist Resident 5 routinely per toileting schedule, which included before and after all meals throughout the day, before bed, at night, and at least once during NOC shift or anytime Resident 5 called for toileting assistance. - The ISP did not document fall preventions. Resident 5's progress notes, dated 09/01/2025 to 10/27/2025, documented the following behavioral concerns: 09/07/205: Aggressive. Walking through the hallway naked. 09/12/2025: Eloped without pants on. 09/16/2025: Awake all night. Throwing used wipes at staff. 09/20/2025: Wandering in others' room. Had a bowel movement in another resident's shower. Physically aggressive and cursing during shower. 09/23/2025: Verbally aggressive. 10/01/2025: Became very upset during personal cares and struck out at caregiver. 10/04/2025: Punched caregiver. Required assistance of 3 caregivers to dress when s/he was ambulated in the nude with feces on him/her. Resident threw feces at caregiver. 10/12/2025: Wandering in other's room. Had bowel movement in another resident's room. Resident 5's record also documented an unwitnessed fall on 10/17/2025. On 10/27/2025 at approximately 11:00 a.m., Surveyor requested Resident 5's assessments from Regional Wellness Director C and received the following: - Elopement assessment, dated 11/27/2024, which stated "Red flag behaviors. Re assess as needed if new behaviors occur.	N 381		

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N 381	Continued From page 18 - Fall assessment, dated 11/27/2024. Resident 5's record did not include a behavior assessment when s/he had been exhibiting signs of aggression, disrobing, defecating in other residents' rooms, and wandering into other residents' rooms. Resident 5 did not have an updated elopement assessment after his/her elopement on 09/12/2025. Resident 5 did not have an updated fall assessment after his/her 10/17/2025 fall. Example 2 - Resident 12 On 10/27/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 12's record. Resident 12 admitted to the provider's facility on 09/10/2024 with diagnoses including Parkinson's disease and neurocognitive disorder with Lewy bodies. Resident 12's ISP, last updated 08/27/2025, included the following fall preventions: frequent safety/toileting checks, ensure proper footwear is being worn, ensure walker is used, ensure room is free of clutter, standby assist with ambulation, assist of 1 with wheelchair when tired, escort when needed and engage in activities to maintain strength and balance. Resident 12's record included incident reports of falls on 09/20/2025, 09/26/2025, 09/27/2025, 10/01/2025, 10/09/2025, 10/11/2025, 10/17/2025, 10/20/2025, 10/24/2025 and 10/25/2025. The incident reports did not include an assessment to determine if Resident 12 had a change in needs to prevent further falls. Resident 12's most recent fall assessment was dated 06/25/2025. Example 3 - Resident 13: On 10/27/2025 at approximately 10:00 a.m.,	N 381		

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N 381	Continued From page 19 Surveyor reviewed Resident 13's record. Resident 13 was admitted to the provider's facility on 10/22/2024 with diagnosis of dementia. Resident 13 discharged on 10/23/2025. Resident 13's record documented an unwitnessed fall from his/her broda chair on 10/12/2025. Documentation of the fall did not include an assessment to determine if Resident 13 had a change in needs to prevent further falls. Resident 13's most recent fall assessment was dated 08/18/2025. On 10/27/2025 at 5:23 p.m., Surveyor received follow up documentation from Regional VP of Operations B. Documentation did not include assessments regarding any of the examples above. Example 4 - Resident 8: On 10/27/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider's facility on 12/04/2024 with diagnoses including coronary artery disease, type 2 diabetes with diabetic chronic kidney disease, and deep vein thrombosis. Resident 8's face sheet listed hospice information, but there was no start date listed. Resident 8 discharged from the facility on 09/25/2025. Resident 8's ISP, dated 05/23/2025, included the following fall preventions: providing routine room checks throughout the day and night to make sure Resident 8 was safe and making sure Resident 8 was wearing his/her call pendant at all times. Resident 8's record included incident reports of falls on 08/27/2025 and 09/22/2025. Resident 8's record did not include an assessment to determine if Resident 8 had a change in needs to prevent further falls. Resident 8's most recent fall risk assessment was dated	N 381		

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N 381	Continued From page 20 06/04/2025. INTERVIEWS: On 10/27/2025 at 10:50 a.m., Surveyor interviewed Receptionist R. Receptionist R stated s/he observed Resident 5 wander into others' rooms, take things from other residents, be aggressive, throw feces and walk nude in the hallway quite often. Receptionist R stated the provider didn't seem to have interventions in place to manage the behaviors. On 10/27/2025 at 11:50 a.m., Surveyor interviewed Med Tech N. Med Tech N stated Resident 5's behaviors were so unpredictable and unprovoked. Med Tech N stated s/he has had feces thrown in his/her hair by Resident 5. Med Tech N stated s/he didn't feel management was responsible to Resident 5's behavioral concerns. On 10/27/2025 at 1:30 p.m., Surveyor interviewed Caregiver Q. Caregiver Q stated Resident 5 was very abusive and difficult to manage. On 10/27/2025 at 3:00 p.m., Surveyors reviewed concern with Regional VP of Operations B, Regional Wellness Director C, Executive Director J, VP of Clinical Operations K and Associate Administrator L that residents did not have updated assessments related to falls or behaviors. Regional VP of Operations B stated the provider had completed a lot of education with caregivers that managing Resident 5's behaviors was all in the approach to Resident 5. Regional VP of Operations B stated when management worked with Resident 5, Resident 5 did not exhibit behaviors because they approached Resident 5 in a calm manner.	N 381		

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N 388	Continued From page 21	N 388		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 6 individual service plans (ISP) reviewed were followed. Resident 11's sling was left underneath him/her on more than 1 occasion resulting in skin breakdown. Resident 13 was in his/her broda chair with a non-working chair alarm. This is a repeat deficiency. See Statement of Deficiency (SOD) 5LT211, dated 05/07/2025. Findings include: From 10/27/2025 to 10/30/2025, Surveyors conducted a standard survey, 2 verification visits and 3 complaint investigations. The following concerns with following ISPs were identified: Example 1 - Resident 11: On 10/27/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 11's record. Resident 11 was admitted to the provider's facility on 05/20/2025 with diagnosis of dementia. Resident 11's ISP documented the following: - ISP dated 06/18/2025: Transfers - Hoyer lift of 2 staff for all transfers. - ISP update 09/02/2025: Use green hoyer sling	N 388		

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N 388	Continued From page 22	N 388		

for transfers only and remove after using. Use shower sling for showers only.
- ISP update 09/22/2025: Please do not leave sling under resident while up in chair to prevent skin breakdown. Only use shower sling when transferring in/out of shower.

Facility progress notes, dated 08/13/2025, stated Resident 11 was observed lying in bed on top of his/her sling. Upon changing Resident 11, staff observed his/her skin irritated, and a piece of his/her skin fell off of his/her upper thigh. A follow up note stated, "[Resident 11]'s sling was left on over the night and caused the skin injury."

On 10/29/2025 at 1:00 p.m., Surveyor reviewed hospice records, obtained by Surveyor. Hospice records, dated 09/01/2025 to 10/23/2025, documented Resident 11 was found with a hoyer sling underneath him/her on 09/15/2025, 09/26/2025 and 10/13/2025. Documentation also stated Resident 11 was found with indentation from shower sling being left on him/her on 09/22/2025.

On 10/30/2025 at approximately 6:00 a.m., Surveyor shared concern that Resident 11's sling was left underneath him/her on more than 1 occasion resulting in skin breakdown.

On 10/30/2025 at approximately 6:00 p.m., Regional VP of Operations B acknowledged Surveyor's concern and stated a "Notification of Change in Individual Service Plan" was completed on 09/02/2025 indicating staff were to use only green hoyer sling with transfers and remove after using, shower sling for showers only, and staff to report any skin changes to Wellness Director and hospice nurse.

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N 388	Continued From page 23 Example 2 - Resident 13: On 10/27/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 13's record. Resident 13 was admitted to the provider's facility on 10/22/2024 with diagnosis of dementia. Resident 13 discharged on 10/23/2025. Resident 13's ISP, dated 08/19/2025, documented s/he was a high fall risk, used a broda chair with a chair alarm for safety related to sliding out of his/her wheelchair and had a reminder for staff to ensure tab alarm was on when Resident 13 was in bed or his/her broda chair. A progress note, dated 10/12/2025, stated Resident 13 experienced an unwitnessed fall out of his/her broda chair in the dining room. The note did not reference Resident 13's chair alarm. Regional Wellness Director C stated s/he was unable to locate an incident report for the fall. On 10/29/2025 at 1:00 p.m., Surveyor reviewed hospice records, obtained by Surveyor. Hospice records, dated 09/01/2025 to 10/23/2025, documented Resident 13 had an unwitnessed fall on 10/12/2025. The note stated another resident reported Resident 13 was reaching for an item and fell from the broda chair. The note documented Resident 13's alarm was nonworking at the time of the fall and when facility staff was asked for batteries for the chair alarm, facility staff reported alarms were not allowed at the time. On 10/30/2025 at approximately 6:00 a.m., Surveyor shared concern with Regional VP of Operations B that Resident 13 did not have a working alarm on at the time of his/her 10/12/2025 fall. On 10/30/2025 at approximately 5:00 p.m.,	N 388		

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N 388	Continued From page 24 Regional VP of Operations B stated the tab alarm was addressed in Resident 13's ISP and that s/he was unable to identify if the alarm was present at the time of the fall. Regional VP of Operations B stated facility staff were informed the provider preferred not to have alarms as evidence-based practice indicated they cause a higher risk of falls; however, if hospice already had alarms in place for an intervention the provider was to continue to use them.	N 388		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 6 individual service plans (ISP) reviewed were updated when there was a change of condition in the resident's needs, abilities or physical or mental condition. Resident 8's ISP was not updated to include his/her need for hospice services, assistance with	N 389		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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mobility, incontinence cares, bathing assistance, repositioning and oxygen use.

This is a repeat deficiency. See Statement of Deficiency (SOD) 5LT211, dated 05/07/2025.

Findings include:

On 10/27/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider's facility on 12/04/2024 with diagnoses including coronary artery disease, type 2 diabetes with diabetic chronic kidney disease, and deep vein thrombosis. Resident 8's face sheet listed hospice information, but there was no start date listed. Resident 8 discharged from the facility on 09/25/2025. Resident 8's ISP, dated 05/23/2025, documented the following:

-Ambulation - Ambulates independently with walker.
-Toileting - Continent of bowel and bladder and manages independently.
-Bathing - Requires stand-by assist for showering.
-Falls - Routine room checks, ensure call pendant is being worn at all times.
-Hospice Resident - Not applicable.

On 10/27/2025 at 11:05 a.m., Surveyor interviewed Regional Wellness Director C about Resident 8's ISP. Regional Wellness Director C stated, "We use our own care plan and go through it with hospice." Regional Wellness Director C indicated s/he was unable to access the hospice care plan or notes for Resident 8 since s/he had discharged from the facility.

On 10/27/2025 at approximately 10:00 a.m.,

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N 389	Continued From page 26 Surveyor reviewed Resident 8's facility observation notes from 08/01/2025 to 10/01/2025 and medication administration record (MAR) for September 2025, which documented the following: -Note on 09/11/2025 at 10:00 a.m.: Met with RN from [hospice]. Request out to clarify oxygen orders and to send parameters with order. Clarified shower schedule and care plan. -Note on 09/11/2025 at 12:30 p.m.: ...Staff to provide peri care after each incontinence episode and reposition frequently. -MAR: Order - Toilet and reposition (Start Date: 09/16/2025) - Toilet and reposition (off load weight on buttocks) every 2-3 hours. -MAR: Order - Oxygen 2L/min (Start Date: 09/19/2025) - Place oxygen if [Resident 8] complains of difficulty breathing or shows signs of breathing issues (blue lips/fingers, change in alertness, labored breathing, gasping breaths). On 10/29/2025 at 1:00 p.m., Surveyor reviewed hospice records, obtained by Surveyor. Hospice records indicated Resident 8 began hospice care on 08/07/2025. Hospice records, dated 09/01/2025 to 09/25/2025, documented the following: -09/03/2025 - Hospice nurse noted episodes of urinary incontinence -Resident 8 was admitted to the hospital from 09/04/2025 to 09/08/2025 and discharged back to the facility. -Hospice updated their care plan on 09/08/2025 to include the following changes: Ambulation - Assist with ambulation with walker for short distances and assist with wheelchair for long distances / Toileting - Bedside commode added, requires supervision/assistance / Bathing -	N 389		

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N 389	Continued From page 27 Shower / Supervision / assistance and Falls - discharged on 2 liters of oxygen via nasal cannula; added oxygen use and tubing to fall precautions. -09/09/2025 - Hospice nurse noted episodes of urinary and bowel incontinence On 10/30/2025 at approximately 6:00 a.m., Surveyors shared concern with Regional VP of Operations B that Resident 8's ISP did not reflect his/her change in needs. On 10/30/2025 at approximately 5:00 p.m., Regional VP of Operations B acknowledged Resident 8's change in needs and stated s/he was unable to find documentation of an updated ISP to reflect Resident 8's change in needs.	N 389		
N 425	83.38(1)(a) Personal care. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Personal care. Personal care services shall be designed and provided to allow a resident to increase or maintain independence.	N 425		

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N 425	Continued From page 28 This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 3 of 6 residents reviewed received assistance with personal cares. This is a repeat deficiency. See Statement of Deficiency (SOD) HT4311, dated 06/26/2025. Findings include: From 10/27/2025 to 10/30/2025, Surveyors investigated 3 complaint investigations alleging care concerns. The following concerns were identified: RECORD REVIEW: Resident 13: On 10/27/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 13's record. Resident 13 was admitted to the provider's facility on 10/22/2024 with diagnosis of dementia. Resident 13 discharged on 10/23/2025. Resident 13's individual service plan (ISP), dated 08/19/2025, documented Resident 13 required assistance with all personal cares, including incontinence cares, and required a mechanical lift with assist of 2 for transfers. Resident 13's progress notes documented the following care concerns: - 09/20/2025: Resident was found heavily saturated in AM as if no cares were given throughout the night. Resident was found in his/her chair as if cares were about to be given but not completed before shift change. Noted rash in groin area. On 10/29/2025 at 1:00 p.m., Surveyor reviewed	N 425		

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hospice records, obtained by Surveyor. Hospice records, dated 09/01/2025 to 10/23/2025, documented Resident 13 was found wearing 2 briefs on 09/15/2025 and 09/23/2025. The notes documented staff were educated after each occurrence to not place 2 briefs on Resident 13. A hospice record, dated 09/10/2025, documented that facility staff reported to hospice staff, who was assisting with incontinence cares, Resident 13 had not been checked or changed in the past 6 hours.

Resident 11:

On 10/27/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 11's record. Resident 11 was admitted to the provider's facility on 05/20/2025 with diagnosis of dementia. Resident 11's ISP, updated 09/22/2025, documented Resident 11 required assistance with personal cares, including incontinence cares and a hoyer lift with assist of 2 for transfers.

On 10/29/2025 at 1:00 p.m., Surveyor reviewed hospice records, obtained by Surveyor. Hospice records, dated 09/01/2025 to 10/23/2025, documented Resident 11 was found wearing 2 briefs on 09/08/2025, 09/15/2025, 09/22/2025, 09/30/2025. The notes documented staff were educated after each occurrence to not place 2 briefs on Resident 11.

Resident 8:

On 10/27/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 8's record. Resident 8 was admitted to the provider's facility on 12/04/2024 and discharged on 09/25/2025. Resident 8's ISP, dated 05/23/2025, documented s/he was independent with toileting.

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N 425	Continued From page 30 On 10/29/2025 at 1:00 p.m., Surveyor reviewed hospice records, obtained by Surveyor. Hospice records indicated Resident 8 began hospice care on 08/07/2025. The hospice care plan, updated 09/08/2025, documented Resident 8 required assistance with ambulation, toileting and bathing. Hospice records, dated 09/01/2025 to 09/25/2025, documented the following concerns: - 09/10/2025: Facility called hospice nurse and said facility staff were refusing to get Resident 8 out of bed to shower after Resident 8 was soiled and covered in emesis. Facility staff claimed hospice staff directed them not to get resident out of bed, which hospice nurse indicated was not true and was not reflected in Resident 8's care plan. -09/16/20205: Hospice nurse visited in afternoon and changed Resident 8's brief, which was soiled. Resident 8 indicated it had not been changed all day. INTERVIEW: On 10/27/2025 at 11:50 a.m., Surveyor interviewed Med Tech N, who worked 1st shift. Med Tech N stated s/he had observed residents, including Resident 13, Resident 11, Resident 14 and Resident 15 wearing 2 briefs and saturated when doing AM rounds. On 10/27/2025 at 1:30 p.m., Surveyor interviewed Caregiver Q. Caregiver Q stated residents were frequently very saturated when s/he arrived to work at 6:00 a.m. Caregiver Q stated Resident 15 had been found with dry feces on him/her and Resident 11 had been found soaked through 2 depends.	N 425		

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N 425	Continued From page 31 On 10/27/2025 at 3:00 p.m., Surveyors reviewed personal care concerns with Regional VP of Operations B, Regional Wellness Director C, Executive Director J, VP of Clinical Operations K and Associate Administrator L. None of the individuals present from the facility commented on the care concerns identified by Surveyors. On 10/30/2025 at approximately 6:00 a.m., Surveyor shared concern with Regional VP of Operations B that Resident 11 and Resident 13 were found by hospice wearing 2 briefs on more than 1 occasion. Surveyor shared care concerns identified by hospice for Resident 8. On 10/30/2025 at approximately 5:00 p.m., Regional VP of Operations B responded to Surveyors' concern stating that a "Notification of Change in Individual Service Plan" had been completed for Resident 11 and Resident 13 to not place 2 briefs on the resident. Regional VP of Operations B stated s/he was unable to locate a "Notification of Change in Individual Service Plan" for Resident 8.	N 425		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical	N 431		

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N 431	Continued From page 32 health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 6 residents reviewed had their health monitored. Resident 2's physician was not notified of blood sugars >339 as ordered. This is a repeat deficiency. See Statement of Deficiency (SOD) 5LT211, dated 05/07/2025 and SOD HT4311, dated 06/26/2025. Findings include: From 10/27/2025 to 10/30/2025, Surveyors conducted 2 complaint investigations that alleged concerns with diabetic management at the facility RECORD REVIEW: On 10/27/2025 at approximately 10:00 a.m., Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider's facility on	N 431		

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N 431	Continued From page 33 10/07/2024 with diagnosis of diabetes. Resident 2's physician orders included Insulin Lispro 100 unit/ml (Start Date: 09/15/2025) - 3 times daily at morning, noon and evening after meals per sliding scale of 0-139=0 units, 140-164=1 unit, 165-189=2 units, 190-214=3 units, 215-239=4 units, 240-264=5 units, 265-289=6 units, 290-314=7 units, 315-339=8 units, >339=Notify MD. Resident 2's medication administration record (MAR), dated 10/01/2025 to 10/27/2025, documented the following occurrences of Resident 2's blood sugar (BS) being >339: - 10/03/2025 8:31 a.m. BS=395 - 10/10/2025 8:21 a.m. BS=400 Review of Resident 2's record did not indicate Resident2 's physician was notified of the 10/03/2025 and 10/10/2025 BS >339. On 10/27/2025 at 3:00 p.m., Surveyors reviewed concern with Regional VP of Operations B, Regional Wellness Director C, Executive Director J, VP of Clinical Operations K and Associate Administrator L that Resident 2's physician was not notified of all BS >339. Regional Wellness Director C stated it would be the responsibility of the medication passer to notify the physician of a BS >339.	N 431		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas:	N 432		

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N 432	Continued From page 34 Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 6 residents reviewed received medication administration services to meet their needs. Resident 3 was administered Insulin Lispro 100 unit/ml out of a pen that was not labeled or supplied to him/her. Findings include: From 10/27/2025 to 10/30/2025, Surveyors conducted 2 complaint investigations alleging concerns with medication administration. On 10/27/2025 at approximately 9:30 a.m., Surveyors requested documentation of medication errors at the facility from Regional Wellness Director C. On 10/27/2025 at approximately 10:30 a.m., Surveyor received documentation from Regional Wellness Director C that documented that s/he was informed by Med Tech M and Med Tech N on 10/14/2025 that Resident 3 was out of his/her Insulin Lispro. The document stated Regional Wellness Director C provided Med Tech M with an Insulin Lispro pen from Regional Wellness Director C's delegation bag, which s/he had obtained from in-house stock. On 10/27/2025 at approximately 10:45 a.m.,	N 432		

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N 432	Continued From page 35 Surveyor shared concern with Regional Wellness Director C about the provider having in-house stock. Regional Wellness Director C clarified that the insulin pen came from the supplies s/he used to delegate med techs on insulin administration. Surveyor requested documentation of Regional Wellness Director C obtaining insulin from a pharmacy for delegation purposes. On 10/27/2025 at 11:50 a.m., Surveyor interviewed Med Tech N. Med Tech N stated Regional Wellness Director C instructed Med Tech N to administer Resident 4's insulin to Resident 3 earlier in the month when Resident 3 had run out of his/her insulin. On 10/27/2025 at approximately 1:00 p.m., Surveyor reviewed Resident 3's record. Resident 3 admitted to the provider's facility on 08/23/2024. Resident 3 had a physician order for Insulin Lispro 100 unit/ml (Start Date: 09/04/2025) - Inject 10 units 3 times daily morning, noon and evening. The Medication Administration Record (MAR), dated 10/01/2025 to 10/27/2025, indicated Resident 3 received his/her Insulin Lispro 100 unit/ml on 10/14/2025. On 10/27/2025 at 2:35 p.m., Surveyor interviewed Med Tech M. Med Tech M stated on 10/14/2025 Resident 3 had run out of Insulin Lispro and s/he was instructed by Regional Wellness Director C to use one of Resident 4's insulin pens. Med Tech M stated s/he observed the insulin pen taken from a box of insulin labeled for Resident 4. On 10/27/2025 at 3:00 p.m., Surveyors reviewed concern with Regional VP of Operations B, Regional Wellness Director C, Executive Director J, VP of Clinical Operations K and Associate Administrator L that Resident 3 was administered	N 432		

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N 432	Continued From page 36 Insulin Lispro 100 unit/ml from a pen that was not labeled or supplied for him/her. Surveyor shared that med techs stated they were instructed to use Resident 4's insulin for Resident 3 and that Surveyor had not received documentation indicating Regional Wellness Director C had an in-house stock of insulin for delegation purposes. Regional Wellness Director C stated s/he could not provide Surveyor with his/her delegation bag to observe the insulin supply because s/he did not have the delegation bag with him/her. Regional Wellness Director C confirmed that Resident 3 was administered Insulin Lispro that was not labeled for him/her or supplied to him/her on 10/14/2025.	N 432		
N 441	83.39(3) Hand washing. Employees shall follow hand washing procedures according to centers for disease control and prevention standards. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure each employee followed hand washing procedures according to Centers for Disease Control and Prevention (CDC) standards. Caregiver O did not wash or sanitize his/her hands or change gloves after touching two different residents' foods and assisting them with eating. Findings include: The Centers for Disease Control and Prevention (CDC) published the following article on 02/27/2024: "Clinical Safety: Hand Hygiene for	N 441		

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N 441	Continued From page 37 Healthcare Workers" (https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html). This guideline details the standard for caregivers regarding glove use and hand washing to prevent the spread of infections. The CDC has recommended that caregivers change gloves and clean hands when moving from care on one patient to another patient. On 10/27/2025 from 8:10 a.m. to 8:45 a.m., Surveyor observed Caregiver O assisting Resident 10 and Resident 11 with eating breakfast. Caregiver O put gloves on before assisting the residents with breakfast. Surveyor observed Caregiver O break up Resident 10's food on his/her tray with his/her hands and feed Resident 10 toast without utensils, bringing his/her gloved hands to Resident 10's mouth. Caregiver O repeated this with Resident 11, bringing toast to his/her mouth without using utensils and without changing gloves or performing hand hygiene. Surveyor observed Caregiver O touching his/her face with the same gloves on. Caregiver O also stood up from the table, using his/her gloved hands to push up on the arms of the chair, returned to the table, and touched Resident 10's oranges with his/her gloved hand without changing gloves or performing hand hygiene. On 10/27/2025 at 3:00 p.m., Surveyors reviewed hand hygiene concerns with Regional VP of Operations B, Regional Wellness Director C, Executive Director J, VP of Clinical Operations K and Associate Administrator L. None of the individuals present from the facility commented on the hand hygiene concerns identified by Surveyors.	N 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 481	Continued From page 38	N 481		
N 481	83.43(1) Environment safe, clean, and comfortable Environment. The CBRF shall provide a living environment that is safe, clean, comfortable, and homelike. All common dining and living areas shall contain furnishings appropriate to the intended use of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure a clean environment was provided. Findings include: On 10/27/2025 at approximately 8:10 a.m., Surveyor toured the provider's facility and observed the following concerns: - Resident 16 had a soiled glove on the floor next to his/her garbage, that had no bag in it. Soiled laundry was overflowing in his/her laundry basket located in his/her shower. - Resident 9 had a soiled chuck paid in his/her laundry, leaving a urine odor in his/her room. - Resident 14 had an overflowing laundry basket in his/her room, with clothing falling over the top. - Resident 12 had laundry, including bedding and chuck pads, piled up on his/her bathroom floor. Resident 12's toilet paper holder was also broken, with 2 of the 3 pieces lying on the floor. - Resident 11 had over the toilet grab bars sitting on his/her bathroom floor. Surveyor asked Caregiver T why the grab bars were lying on the floor. Caregiver T stated s/he was unsure because Resident 11 didn't use them. On 10/27/2025 at 11:50 a.m., Surveyor	N 481		

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	0019471	A. BUILDING: _____ B. WING _____	R-C 10/30/2025

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N 481	Continued From page 39 interviewed Caregiver N. Caregiver N stated staff was unable to keep up with resident laundry and that the overnight shift didn't help at all. Caregiver N stated management had informed staff that additional housekeeping or laundry staff would not be provided due to the current census. On 10/27/2025 at 3:00 p.m., Surveyors reviewed housekeeping concerns with Regional VP of Operations B, Regional Wellness Director C, Executive Director J, VP of Clinical Operations K and Associate Administrator L. None of the individuals present from the facility commented on the concerns identified by Surveyors.	N 481		
Y3234	50.09(1)(e) Treatment (1) RESIDENTS' RIGHTS. Every resident in a nursing home or community based residential facility shall, except as provided in sub. (5), have the right to: (e) Be treated with courtesy, respect and full recognition of the resident's dignity and individuality, by all employes of the facility and licensed, certified or registered providers of health care and pharmacists with whom the resident comes in contact. This Rule is not met as evidenced by: Based on observation and interview, the provider	Y3234		

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Y3234	Continued From page 40	Y3234		

did not ensure all residents were treated with courtesy.

Residents that preferred to eat in their rooms and/or required assistance with eating were served greater than 1 hour after mealtime and meals were served cold at times.

This is a repeat deficiency. See Statement of Deficiency (SOD) 5LT211, dated 05/07/2025.

Findings include:

From 10/27/2025 to 10/30/2025, Surveyors conducted a complaint investigation alleging concerns with mealtimes. Surveyors identified the following concerns:

Example 1 - Serving Time:

On 10/27/2025 at 8:05 a.m., Surveyor observed a sign in the provider's dining room that listed mealtimes as breakfast at 8:00 a.m., lunch at 12:00 p.m. and dinner at 4:30 p.m.

On 10/27/2025 at 8:07 a.m., Surveyors observed caregivers begin serving residents breakfast, which consisted of eggs, toast and oranges, in the provider's dining room.

On 10/27/2025 at 8:16 a.m., Surveyor interviewed Caregiver T. Caregiver T identified Resident 15, Resident 2 and Resident 7 as residents that preferred breakfast in their rooms. Caregiver T stated Resident 15 was "transitioning" and required assistance with eating.

On 10/27/2025 at 8:31 a.m., Surveyor observed Cook S plate 3 breakfast meals into Styrofoam to-go containers and place the containers on the

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Y3234	Continued From page 41 counter. On 10/27/2025 at 9:00 a.m., Surveyor observed residents in the dining room had completed breakfast and Caregiver O was cleaning tables. The 3 breakfast meals in Styrofoam containers remained on the counter. Surveyor asked Caregiver O when meals would be delivered to residents who wished to eat in their room. Caregiver O replied, "Oh. I'll go do that now." On 10/27/2025 at 9:03 a.m., Surveyor observed Resident 15 in bed. Med Tech N had just begun administering Resident 15's medications. Surveyor asked if Resident 15 had breakfast. Med Tech N replied, "No. I don't think they have brought it down yet." On 10/27/2025 at 9:06 a.m., Surveyor observed Caregiver O gather drinks and grab the 3 Styrofoam containers to deliver to resident rooms. Surveyor asked Caregiver O how the food was kept at a safe temperature to serve. Caregiver O touched the Styrofoam container and looked at Surveyor with no response. Surveyor touched the containers and noted the containers were not warm to touch. Surveyor asked Caregiver O if s/he had a thermometer to check the temperature and ensure the food was safe to eat. Caregiver O replied, "No. I could warm [the food] up, but I'm afraid I would warm it too much." Surveyor requested Caregiver O check with dietary staff to ensure the food was safe to serve. On 10/27/2025 at 9:25 a.m., Surveyor observed that new food had been prepared, and meals were about to be served to Resident 15, Resident 2 and Resident 7. On 10/27/2025 at 10:50 a.m., Surveyor	Y3234		

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Y3234	Continued From page 42	Y3234		

interviewed Receptionist R. Receptionist R stated meals were often delivered to resident rooms late due to staffing concerns. Receptionist R stated there wasn't enough staff to help in the dining room, so s/he often helped with set up, serving and cutting up food when able.

On 10/27/2025 at 1:30 p.m., Surveyor interviewed Caregiver Q. Caregiver Q stated s/he was often left to assist a table of 4 with feeding by him/herself. Caregiver Q stated residents that required assistance with eating and residents that preferred to eat in their room were served last and often ended up with cold food.

Example 2 - Feeding Assistance:

On 10/27/2025 at 8:22 a.m., Surveyor observed Caregiver P assist Resident 9 with feeding while standing next to him/her. Caregiver P continued to stand over Resident 9 for the duration of feeding Resident 9 breakfast.

"Here are 7 tips to assist individuals living with dementia with eating: ... Remember, meals are social events that we all enjoy. Take time to sit with the person. You can offer companionship and conversation, and if the person needs any reminders or assistance, you'll be there to help." (Source: Alzheimer's Foundation of America Website, Eating and Dementia, 2025, https://alzfdn.org/eating-tips/ (retrieval date - October 30, 2025).)

On 10/27/2025 at 3:00 p.m., Surveyors reviewed concerns with meals with Regional VP of Operations B, Regional Wellness Director C, Executive Director J, VP of Clinical Operations K and Associate Administrator L. None of the individuals present from the facility commented

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Y3234	Continued From page 43 on the concerns identified by Surveyors.	Y3234		